**Blue Print Final Exam N110 F2012**

**Professional Nursing**

**All Chapters found in Kozier unless otherwise stated**

**Historical Perspectives chap 1= 2 question**

1. **What role does the ANA, State BON, NSNA play in nursing?**
   * **Changes in policy at the state and federal level**
   * **Which body would act at the federal level?**
   * Professional Nursing organizations
     + Participation in nursing associations
     + Their role is to establish and implement standards of practice
       - Social, political, and economic arrangements by which practitioners control their practice, self-discipline, working conditions, and professional affairs
     + Their existence also helps define nursing as a profession (instead of an occupation)
   * **ANA**
     + “advances the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.” (ANA, 2009c)
     + Standards of Practice (describe the responsibilities for which the nurse is accountable)
       - Assessment
       - Diagnosis
       - Outcomes Identification
       - Planning
       - Implementation
         * Coordination of Care
         * Health Teaching & Health Promotion
         * Consultation (advanced practice nurses and nurse specialists give consultation)
         * Prescriptive Authority and Tx (for advanced practice nurses)
       - Evaluation
     + Standards of Professional Performance (describe behaviors expected in the professional nursing role)
       - Ethics
       - Education
       - Evidence-Based Practice and Research
       - Quality of Practice
       - Communication
       - Leadership
       - Collaboration
       - Professional Practice Evaluation
       - Resource Utilization
       - Environmental Health
   * **NSNA**
     + Code of academic and clinical conduct
       - Advocate for the rights of all clients
       - Maintain client confidentiality
       - Take appropriate action to ensure the safety of clients, self, and others
       - Provide care for the client in a timely, compassionate, and professional manner
       - Communicate client care in a truthful, timely and accurate manner
       - Actively promote the highest level of moral and ethical principles and accept responsibility for our actions
       - Promote excellence in nursing by encouraging lifelong learning and professional development
       - Treat others with respect and promote an environment that respects human rights, values, and choice of cultural and spiritual beliefs
       - Collaborate in every reasonable manner with the academic faculty and clinical staff to ensure the highest quality of client care
       - Use every opportunity to improve faculty and clinical staff understanding of the learning needs of nursing students
       - Encourage faculty, clinical staff, and peers to mentor nursing students
       - Refrain from performing any technique or procedure for which the student has not been adequately trained
       - Refrain from any deliberate action or omission of care in the academic or clinical setting that creates unnecessary risk of injury to the client, self, or others
       - Assist the staff nurse or preceptor in ensuring that there is full disclosure and that proper authorizations are obtained from clients regarding any form of treatment or research
       - Abstain from the use of alcoholic beverages or any substances in the academic and clinical setting that impair judgment
       - Strive to achieve and maintain an optimal level of personal health
       - Support access to treatment and rehabilitation for students who are experiencing impairments related to substance abuse and mental or physical health issues
       - Uphold school policies and regulations related to academic and clinical performance, reserving the right to challenge and critique rules and regulations as per school grievance policy
2. **Question on the different types of nursing i.e. primary care nursing and team nursing.**
   * **Patient continuity more likely in primary care**
   * **Different healthcare frameworks**
     + **Frameworks = configurations for the delivery of nursing care**
     + **Managed Care –** emphasis on cost controls, customer satisfaction, health promotion, and preventive services. A business approach which some question – health may be too valuable a commodity. Uses critical pathways.
     + **Case Management –** management by multidisciplinary case managers (who assess, coordinate, implement, and evaluate care for groups of clients). Uses critical pathways.
     + **Patient-Focused Care –** bringing all client needs directly to the client to decrease the number of personnel and steps involved to get the work done. Cross-training is an essential element.
     + **Differentiated Practice -** A system to use nursing personnel most efficiently based on their educational preparation. Enables nurses to assume appropriate roles for their individual capacities.
     + **Case Method –** “total care.” One nurse responsible for and in consistent contact with a group of patients for the entire shift.
     + **The Functional Method –** focuses on the jobs to be completed, and makes sure they are accomplished efficiently. A task-oriented approach that improves productivity by giving authority and responsibility to the person assigning the work to direct and control. One disadvantage to this method is that nonquantifiable aspects of care (such as meeting the client’s emotional needs) may be overlooked
     + **Team Nursing –** coordinating care within a team of RNs, LPNs, and UAPs – where RN delegates but is ultimately responsible for care.
   * **Primary Nursing –** in this system, one nurse is responsible for overseeing the total care of a number of hospitalized clients 24/7 to provide comprehensive, individualized, and consistent care. Obviously, this nurse does not personally deliver all of the care, but she does coordinate it and communicate information about the client to other nurses and HCPs. This type of nursing is not suitable for part-time nurses, as it requires a lot of consistency.

**Legal Aspects Chapter 4 = 4 questions**

1. **To what standard of practice are student nurses held?**
   * **Same as RN**
     + Legally, they are held to the same standard of skill and competence as an RN
   * Nursing students are responsible for their own actions and liable for their own acts of negligence committed during the course of clinical experience
2. **What should a nurse do when she suspects that one of nursing colleagues is working under the influence of alcohol?**
   * **Blow the whistle**
   * The standard to be upheld is that nurses having such issues receive treatment and support instead of discipline and derision
   * Reporting an impaired colleague may be difficult, but may save patients’ lives, the nurse’s license, and possibly even his or her own life
   * Be careful to describe only observed behaviors, not inferences as to what might be happening
   * Practice Guidelines
     + Write a clear description of the situation you believe you should report
     + Make sure that your statements are factual and complete
     + Make sure you are credible
     + Obtain support from at least one trustworthy person before filing the report
     + Report the matter starting at the lowest possible level in the agency hierarchy
     + Assume responsibility for reporting the individual by being open about it. Sign your name on the letter
     + See the problem through once you have reported it
3. **What issues are covered in The Patient’s Bill of Rights?** 
   * **The right to refuse Tx**
   * **The right to refuse a doctor and request a different Dr.**
   * NJ Patient Bill of Rights gives patients the right:
     + To considerate and respectful care consistent with sound nursing and medical practices;
     + To be informed of the name of the physician responsible for coordinating his care;
     + To obtain from the physician complete, current information concerning his diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand;
     + To receive from the physician information necessary to give informed consent prior to the start of any procedure or treatment;
     + To refuse treatment to the extent permitted by law and to be informed of the medical consequences of such action;
     + To privacy to the extent consistent with providing adequate medical care to the patient;
     + To privacy and confidentiality of all records pertaining to the patient's treatment, except as otherwise provided by law or third party payment contract, and to access to those records;
     + To expect that within its capacity, the hospital will make reasonable response to the patient's request for services, including the services of an interpreter in a language other than English if 10% or more of the population in the hospital's service area speaks that language;
     + To be informed by the patient's physician of any continuing health care requirements which may follow discharge and to receive assistance from the physician and appropriate hospital staff in arranging for required follow-up care after discharge;
     + To be informed by the hospital of the necessity of transfer to another facility prior to the transfer and of any alternatives to it which may exist;
     + To be informed, upon request, of other health care and educational institutions that the hospital has authorized to participate in the patient's treatment;
     + To be advised if the hospital proposes to engage in or perform human research or experimentation and to refuse to participate in these projects;
     + To examine and receive an explanation of the patient's bill, regardless of the source of payment, and to receive information or be advised on the availability of sources of financial assistance to help pay for the patient's care, as necessary;
     + To expect reasonable continuity of care;
     + To be advised of the hospital rules and regulations that apply to his conduct as a patient; and,
     + To treatment without discrimination as to race, age, religion, sex, national origin, or source of payment.
4. **A surgical patient is having second thoughts about donating his organ. What would you as the nurse do?**
   * **Don’t just keep your mouth shut – notify the surgeon, who will talk to the patient**
   * Assess etiology of doubts – non-judgmentally and therapeutically
   * Have the client’s healthcare provider answer any questions the client has about the procedure

*Community Nursing Chap 7= no questions*

**Values, Ethics Chap 5 =2 questions**

1. **Examples of nonmaleficence, autonomy, beneficence, and justice**
   * **Autonomy –** the right to make one’s own decisions. The right to self-determination – the nurse has to respect this, and not impose or limit the client’s choices.
     + Example: a client refuses treatment; the nurse complies with this wish – upholding the principle of autonomy
   * **Justice –** fairness.
     + A nurse making home visits finds one client tearful and depressed and knows she could help by staying 30 more minutes to talk. However, that would take time from her next client, who is diabetic and needs a great deal of teaching and observation. The nurse now needs to weigh the facts carefully in order to fairly divide her time among her clients.
   * **Nonmaleficence –** the duty to do no harm. Harm can be intentional or unintentional.
     + **If the doctor orders an inappropriate drug dose, question it!**
     + The nurse does not place the client at risk for any harm that can be anticipated
   * **Beneficence –** the moral obligation to do good or to implement actions that benefit clients and their support persons
     + **You see a lonely patient, and you go talk to them**
     + The nurse promotes the client’s physical and emotional well-being.

*Culture Chap 18 = no questions*

**Communication chap 26=4 questions**

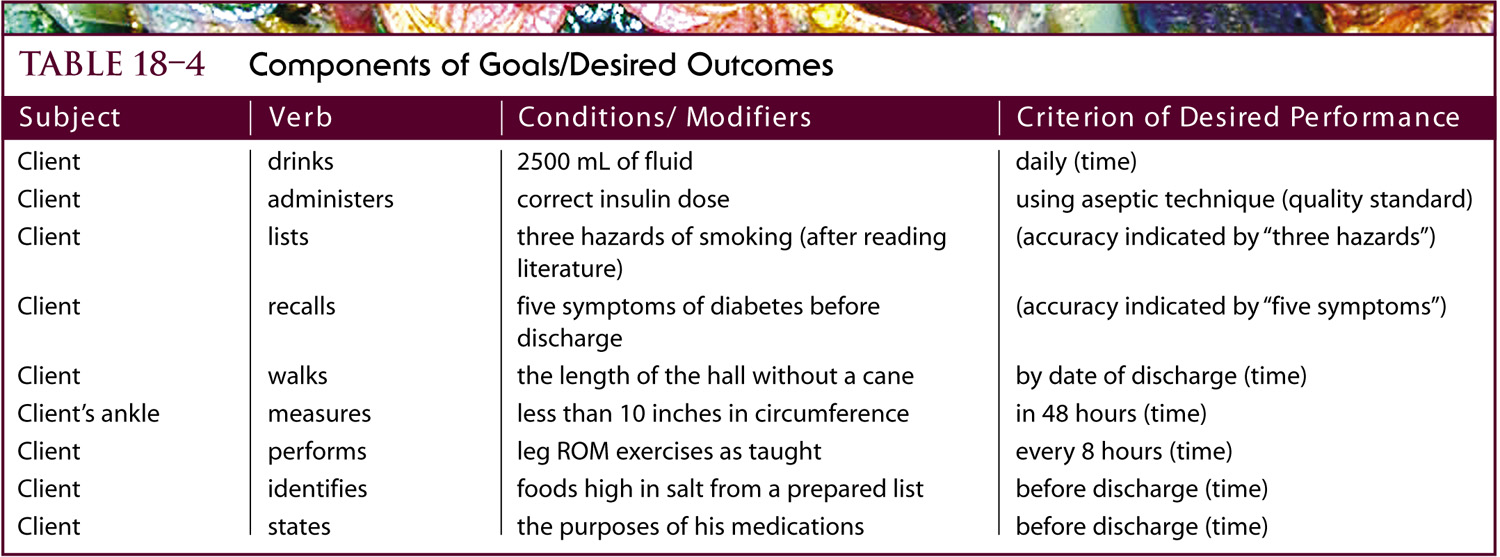
1. **Communication technique used to get patients to talk.**
   * Effective verbal communication
     + **Asking open-ended questions**
     + **Therapeutic communication**
       - Therapeutic communication promotes understanding and can help establish a constructive relationship between the nurse and the client
         * Relate back what a patient just said to encourage further communication/expression of emotions/feelings
         * Provide general leads
         * Seek clarification
         * Acknowledging feelings, changes in behavior, efforts, etc.
     + Appropriate pace and intonation
     + Simplicity
     + Clarity and brevity (succinctness)
     + Appropriate timing and relevance
     + Speech adapted to the particular client
     + Humor (if appropriate)
   * Effective nonverbal communication
     + Offering self
     + Using appropriate body language and gestures
     + Using appropriate facial expression
     + Using appropriate touch
     + Appropriate posture and gait
2. **Assertive communication, when is it appropriate to use.**
   * **When it has to do with patient safety**
   * Assertive communication promotes client safety by minimizing miscommunication with colleagues.
   * People who use assertive communication are honest, direct, and appropriate while being open to ideas and respecting the rights of others.
   * Using “I” statements instead of “you” statements to avoid placing blame and encourage discussion
3. **Effective way to communicate with older adults.**
   * **Speak with a low voice, directly to their face**
   * For clients with special needs such as sensory/cognitive/psychosocial deficits
     + Make sure that assistive devices (including hearing aids/glasses are in good working order)
     + Make referrals to appropriate resources, such as speech therapy
     + Make use of communication aids, such as communication boards, computers, or pictures, when possible
     + Keep environmental distractions to a minimum
     + Speak in short, simple sentences, one subject at a time – and reinforce/repeat what is said when necessary
     + Always face the person when speaking – coming up behind someone may be frightening
     + Include family and friends in the conversation
     + Use reminiscing, either in individual conversations or in groups, to maintain memory connections and to enhance self-identity and self-esteem in the older adult
     + When verbal expression and nonverbal expression are incongruent, believe the nonverbal. Clarify and be attentive of this to promote a feeling of caring and acceptance
     + Find out what has been important and has meaning to the person and try to maintain these things as much as possible – even simple things such as bedtime rituals become important if they are lost in a hospital setting
   * In General
     + Don’t assume sensory/cognitive deficits
     + Do not use elder speak
     + Face the client directly
     + Speak softly (don’t shout)
     + Don’t tower over the client
     + Use therapeutic communication

**Patient teaching chap 27=2 question**

1. **Components of an effective teaching plan for a patient who has to learn to do learn a skill.**
   * Make sure the client is ready to learn
     + Physical readiness – the client isn’t in pain or other distress
     + Emotional readiness – the client isn’t extremely anxious or depressed
     + Cognitive readiness – the client can think clearly. No anesthesia or analgesia is altering the client’s LOC
   * **Make sure the client is motivated to learn**
   * Assess the client’s learning style
   * Assess the client’s understanding of the health problem and why the skill is necessary
     + What is my main problem?
     + What do I need to do?
     + Why is it important for me to do this?
   * Choose appropriate learning content (books, videos, the internet…). Sources should be:
     + Accurate
     + Current
     + Based on learning outcomes
     + Adjusted for the learner’s age, culture, and ability
     + Consistent with information the nurse is teaching
   * Start with what the client knows and then proceed to the unknown
   * Proceed from simple to complex
   * Communicate clearly and concisely
   * Use a layperson’s vocabulary
   * Use an appropriate pace
   * If possible, have the client comfortably out of bed
   * Use tactile learning whenever possible
     + Don’t just use explanation alone
   * **Have the client return a demonstration of the skill**
   * Schedule time for review
     + Repetition reinforces learning

**THE NURSING PROCESS- Critical Thinking, Nursing Diagnosis, Planning, Implementing, Evaluating, Documenting and Reporting Chapter’s 10-15 =7 questions**

1. **At what time do you document on what nursing interventions you have performed?**
   * **ASAP AFTER completion**
   * During the Implementation phase of the nursing process
2. **Examples of subjective and objective data.**
   * **Ob = data**
     + Vital signs
     + Lab work results
     + medical record
     + Physical exam
       - * inspection
         * auscultation
         * Palpation
         * percussion
     + USE YOUR SENSES
   * **Sub = patient’s self-report**
     + “My head hurts”
     + “I’ve been sick for 5 days”
3. **What is the purpose of care plans?**
   * **Road map for care that formalizes it and promotes continuity of care**
     + Contributes to continuity of care
     + Can standardize care for a group of clients (i.e. all those with MI) as well as provide room for individual needs
   * Presents:
     + Admitting Dx
     + Pertinent Medical Hx
     + NDx – problem list (r/t deficits in the client’s well being)
       - Evidence to support these NDx
     + Nursing interventions for each NDx
       - Toward stated goals/outcomes
     + Evaluation of each intervention
   * A complete plan of care integrates dependent and independent nursing functions into a meaningful whole and provides a central source of client information
4. **Supporting evidence for the nursing diagnosis of impaired skin integrity.**
   * **Skin breakdown…**
   * **Dry skin**
   * **Nonblanchable erythema**
     + Or worse…
   * **Low albumin levels** (malnutrition contributes to skin breakdown)
   * Braden scale
     + Quantifies risk for impaired skin integrity
     + Uses multidimensional criteria
   * Incontinence
5. **Examples of nursing goals/outcomes.**
   * **Long-term goal: Patient will state symptoms of disease by discharge**
   * **Short-term goal: Patient will drink eight 8oz glasses of water between 7am and 7pm**
   * NANDA’s Nursing Outcomes Classification (NOC)
     + Taxonomy for describing client outcomes
     + Similar to a goal in traditional language
     + Broadly stated and conceptual
     + Made more specific by identifying indicators that apply to client
     + Includes a five-point scale (a measure) used to rate the client’s status
   * Components of Goal/Desired Outcome Statements
     + Subject
     + Verb
     + Condition or modifier
     + Criterion of desired performance
       - “Client will walk the length of the hall unassisted by 9/15.”

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1. **Placing nursing diagnoses in order of priority.**
   * **Priority Frameworks**
     + ABC’s
     + Maslow’s hierarchy of needs
     + **Bleeding out** is kind of maybe a big deal…
   * Other Priority Factors:
     + Client’s health values and beliefs (which may differ from the nurse’s)
       - A client may believe being home with the children is more important than addressing a health problem
     + Client’s priorities (which may differ from the nurse’s)
       - The client may not view turning in bed as important, whereas the nurse knows just how important it is – Communication is necessary to address this discrepancy
     + Resources available to the nurse and the client
       - Finances, equipment, personnel may not be available, which may postpone the ability to address the NDx, potentially lowering it on the list of priorities
     + Urgency of the health problem
       - *Ineffective Airway Clearance* is more important than *Anxiety r/t hospitalization*
     + Medical treatment plan
       - If an MD orders bed rest, then even if the client highly values becoming ambulatory, walking will have to take lower priority

**Wellness/Illness**

**Health Promotion Chap 16= 1 question**

1. **Know Maslow’s hierarchy needs basic.**
   * Hierarchy:
     + Physiologic Needs
       - necessary for survival – air, food, water, shelter, rest, sleep, activity, and temperature maintenance
     + Safety and Security Needs
       - physical/psychosocial – environment/relationships
     + Love and Belonging Needs
       - Giving/receiving affection, attaining a place in a group, maintaining a feeling of belonging
     + Self-Esteem Needs
       - for self: feelings of independence, competence, and self respect; from others: recognition, respect, appreciation
     + Self-Actualization Needs
       - Innate need to develop one’s maximum potential and realize one’s abilities and qualities
   * Nurses use this framework:
     + To respond therapeutically to client needs
       - To prioritize and plan interventions
       - To assess behaviors
   * To understand themselves and their own responses to needs

*Health, Wellness and Illness Chap 17= no questions*

*Concepts of Growth and Development Chap 20 = no questions*

**Promoting Health across the Lifespan Chaps 22, 23=4 questions**

1. **Most prevalent problems for the 20-40 year old age group.**
   * Injury and violence
     + Motor vehicle crashes are the leading cause of death for people age 1-44.
     + Homicide is the 2nd leading cause of death for people age 15-24, but the leading cause of death for African Americans in this age range
     + Physical/Sexual assault
     + IPV – ask: “Do you feel safe at home”
   * Suicide
     + A leading cause of death for young adults – generally resultant of individuals’ inability to cope with pressure, responsibilities, and expectations of adulthood
   * HT
     + For young African American adults, especially men
   * Substance abuse
     + Assess for and teach about drug use and its complications, including smoking
   * STIs
     + Chlamydia is the most common one
   * Eating disorders
     + Obesity is a big problem
   * Certain malignancies
     + Testicular cancer is the most common one in men age 15-35
     + Breast and cervical cancers are most common for women
2. **Emotional issues affecting males age 55.**
   * **Midlife Crisis**
   * This is the time of Generativity vs. Stagnation
   * Stagnation
     + People who are unable to expand their interests at this time and who do not assume the responsibilities of middle age suffer a sense of boredom and impoverishment
     + These people have difficulty accepting their aging bodies, and become withdrawn and isolated
     + They are preoccupied with self and unable to give to others
     + Some may regress to younger patterns of behavior, for example, adolescent behavior, and try to defy the years by changing their dress or even their actions
       - Buying a convertible
       - dyeing hair to get rid of the gray
       - having an extramarital affair
3. **Most appropriate view for a nurse to have when caring for the elderly.**
   * **Patience and respect**
     + Don’t baby or belittle your elders
     + Don’t bring frustration into your interactions – accept the generally slower pace at which an older adult might function as compared to a younger individual
   * **Be aware and sensitive to the issues they may be dealing with, and the changes that occur in older adults**
     + Older adults begin to experience multisystemic deficits as a part of the natural aging process, including sensory and cognitive decline.
     + This may be accompanied by a loss of independence, which can be an emotionally difficult thing to experience for a person who has always been a caregiver
       - It is your job as a gerontological caregiver to help older adults maintain as much independence as possible – empower your clients and strengthen their autonomy
   * **If you’re ageist, don’t work with the elderly!!!**
     + Be aware of your own values and attitudes toward aging
     + Examine whether myths or stereotypes influence your attitude
       - Do you think that all older adults are senile, old-fashioned, unproductive, or inflexible?

*Promoting Family Health Chap 24= no questions*

*Promoting Psychosocial Health*

*Sensory Perception chap 38 = No questions*

*Self-concept chap 39= no questions*

**Sexuality chap 40= 1 question**

1. **Ways in which to prevent sexually transmitted diseases.**
   * **Wear condoms…**
   * Abstain from sex (this may not be a realistic method to teach – it is better to teach preparedness than avoidance)
   * Limit number of sexual partners
   * Follow safe sex practices during oral sex including the use of a dental dam during cunnilingus to prevent STI transmission
   * Talk openly with sex partners about how to have “safer sex” and be honest about STI history
   * Abstain from high-risk sexual activity with a partner known to have or suspected of having an STI
   * Report to a healthcare facility for examination whenever in doubt about possible exposure or when signs of an STI are evident
   * When an STI is diagnosed, notify all partners and encourage them to seek treatment
   * Minimize transfusions of banked blood or blood products. Use autologous transfusions for elective surgery whenever possible.

**Spirituality chap 41=2 questions**

1. **Ways in which a nurse can facilitate a patient’s wish to have access to their spiritual support system.**
   * **Be open-minded**
   * **Give them privacy to pursue these practices**
     + Provide time and privacy for, and provide comfort measures prior to, private worship, prayer, meditation, reading, or other spiritual activities
     + Take large measures of sensitivity and respect to help converse therapeutically with clients about providing spiritual care
     + Some clients may be eager for overt offers of spiritual care, but others may be uncertain or opposed to such offers
   * Most common nursing therapeutics more desired by clients
     + Providing presence
     + Conversing about spirituality
     + Supporting religious practices
     + Assisting clients with prayer
     + Referring clients for spiritual counseling
2. **Qualities needed to be a culturally competent nurse.** 
   * **Be comfortable in your own skin – know your own culture, values, and beliefs**
   * Acquaint yourself with the religions, spiritual practices, and cultures of the area in which you are working
   * Respect, facilitate, and support cultural practices and beliefs
   * Be open-minded and nonjudgmental – don’t hold to stereotypes

**Stress & Coping Chap 42=1 questions**

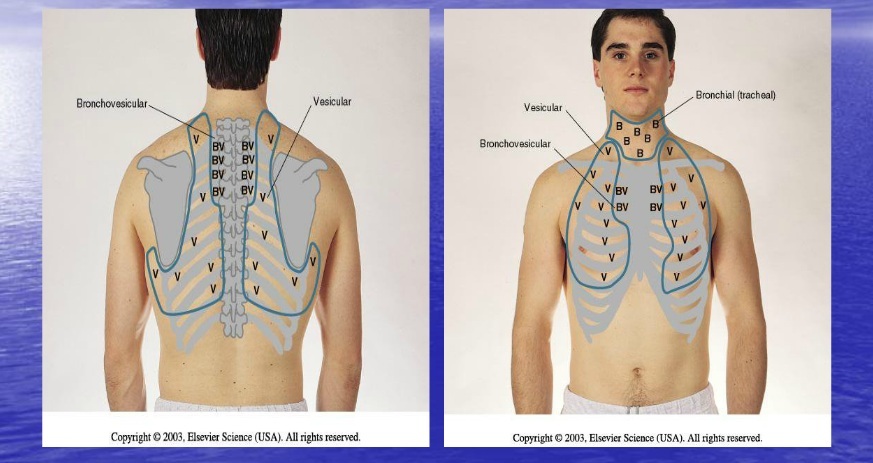
1. **The physiological responses during the phases of the General Adaptation Syndrome**
   * = stress syndrome = release of NE, Epi, and cortisone
   * **S/S**
     + **Tachycardia (not bradycardia)**
     + **Hypertension (not hypotension)**
     + Increased myocardial contractility
     + Bronchodilation
     + Increased blood clotting
     + Increased metabolism
     + Decreased bloodflow to kidneys
     + Increased release of renin (leading to hypertension)
     + Protein catabolism
     + Gluconeogenesis/Glycogenolysis
   * Think of all the SNS activation effects – these are all equivalent to stress responses
   * Prolonged stress S/S
     + Deep peptic ulcers
     + Enlarged adrenal glands
     + Shrinking of lymphatic structures (thymus, spleen, LNs)

**Loss, Grieving, and Death chap 43= 2 question**

1. **What are some ways in which a person can exhibit signs of complicated grief?**
   * **The normal stages of grief are prolonged or exaggerated**
   * Complicated grief = unhealthy grief
   * Preoccupation for more than 6 months, leading to reduced functioning
   * Potential signs of complicated grief
     + Inhibited or delayed grief
       - The client fails to grieve
       - The client avoids visiting the grave and refuses to participate in memorial services, even though the practices are a part of the client’s culture
     + Unresolved, chronic, or exaggerated grief
       - The client becomes recurrently symptomatic on the anniversary of a loss or during holidays
       - The client develops persistent guilt and lowered self-esteem
       - Even after a prolonged period of time, the client continues to search for the lost person. Some may consider suicide to affect reunion
       - A relatively minor event triggers symptoms of grief
       - Even after a period of time, the client is unable to discuss the deceased with composure
       - After the normal period of grief, the client experiences physical symptoms similar to those of the person who died.
       - The client’s relationships with friends and relatives worsen following the death
2. **What should a nurse do if a patient with a living will that indicates he/she is a DNR/DNI is in respiratory distress and is begging for help?**
   * **Do something – help them.**

**Physical Assessment chap 30=5 questions**

1. **How do you assess a dark-complexioned patient for pallor?**
   * The mucous membranes (conjunctiva, oral mucous membranes)
2. **~~At what anatomical location do you assess the mitral valve of the heart?~~**
   * 2nd intercostal space
3. **Normal and adventitious breath sounds heard on auscultation of the lung fields.**

* Normal breath sounds
  + - Bronchial
      * Heard over trachea
      * High pitch, loud, hollow, expiration longer than inspiration
    - Bronchovesicular
      * Heard over main stem bronchus and between scapulae
      * Medium pitch, expiration equals inspiration
    - Vesicular
      * Heard over most of lung field
      * Low pitch, soft & breezy, soft & short expiration, inspiration 2x longer than inspiration
  + Adventitious breath sounds
    - Crackles (rales or crepitations)
      * Mechanism = bubbling of air through fluid or mucus in any air passage and/or sudden opening of deflated airways causing equalization of pressures
      * Description = discrete, non continuous, usually heard on inspiration but can also be heard on expiration. Classified further as coarse, medium, or fine according to pitch
    - Wheezes
      * Mechanism = rapid passage of air through narrowed or partially obstructed airway (asthma)
      * Description = continuous, high-pitched, squeaky musical sounds; audible during inspiration, expiration or both
    - Rhonchi
      * Mechanism = rapid passage of air through narrowed or partially obstructed airway.
      * Description = low pitch, continuous, sonorous
    - Pleural friction rubs
      * Mechanism = alterations in the pleura from inflammation adding friction between pleural layers (rubbing together of inflamed pleural surfaces)
      * Description = dry, rubbing, or grating/creaking sound. Lower pitched and longer than crackles; heard during inspiration and expiration; not relieved by coughing

1. **What is the purpose of psychosocial assessment?**
   * Psychosocial Assessment involves assessing sensory perception, self-concept, sexuality, spirituality, stress and coping, and loss and grief. All of these topics are somewhat abstract, involving intangible aspects of what makes us individuals. They are important in formulating a well-rounded plan of care for clients
   * From a psychosocial assessment you can determine:
     + **Risk factors for problems**
       - **Including determining possible substance abuse problems that can pose withdrawal problems during hospitalization**
     + Intangible deficits in a client’s well-being
       - such as disturbed body image, complicated grieving, or sexual dysfunction
2. **How do you assess a patient’s pedal pulse when they have edema?**
   * **Use a Doppler**
   * **Another method: Slowly try to push away the edema and use as much of the surface of your fingers as possible**

**Promoting Physiological Health/Nursing Management of Adults with Alterations in:**

**Oxygen chap 50=1 questions**

1. **What technique will you use to help mobilize a patient’s pulmonary secretion?**
   * Changing positions frequently, ambulating, and exercising
   * Deep-breathing and coughing
   * Maintaining adequate hydration
     + IVF as ordered, offering water at regular intervals; use of a humidifier
   * Administering medications as ordered
     + Bronchodilators, leurkotreine modifiers, and expectorants (etc) can help patients with secretions
   * Incentive spirometry
     + In relation to secretions, this can help to loosen them
   * Mucus Clearance Devices (MCD)
     + Used for patients with excessive secretions (cystic fibrosis, COPD, bronchiectasis)
     + This is a handheld device that contains a steel ball – when the patient exhales fast into this device, the vibrations of the steel ball causes airway mucus to loosen, and assists mucus movement up the airways to be expectorated
   * PVD = percussion, vibration, and postural drainage
     + **Percussion** (aka clapping)
       - forceful striking of the skin with cupped hands (produces a hollow, popping sound)
       - This can mechanically dislodge tenacious secretions from the bronchial walls – so percuss over congested lung areas
       - Technique:
         * fingers and thumbs held together and flexed slightly to form a cup
         * Cover area with a towel or gown; ask patient to breathe slowly and deeply
         * Percuss each affected lung segment for 1-2 minutes
     + Vibration
       - A series of vigorous quivering produced by hands that are placed flat against the client’s chest wall
       - Normally used after percussion to increase the turbulence of the exhaled air and therefore loosen thick secretions
       - Technique:
         * Place one hand over the other, palms down, over the affected area
         * Ask the client to inhale deeply and exhale slowly through the nose or pursed lips
         * During exhalation, tense all the hand and use arm muscles and vibrate the hands, moving them downward (use mostly the heel of the hand)
         * Stop when the client inhales
         * Vibrate during 5 exhalations over one affected lung segment, then encourage the client to cough and expectorate sputum.
     + Postural drainage
       - Drainage of secretions from various lung segments by gravity.
       - This is accomplished by changing positions – and the position required varies by the area that needs to be cleared
       - Secretions in the trachea and main bronchi are usually coughed into the pharynx where they can be swallowed, expectorated, or effectively removed by suctioning
   * Suctioning
     + The aspiration of secretions through a catheter connected to a suction machine or wall suction outlet
     + Used when patients have difficulty handling their secretions or when artificial airways are in place
       - The nurse must assess the client for evidence that he/she is unable to cough up and/or expectorate secretions
       - Dyspnea, bubbling or rattling breath sounds, cyanosis, or decreased SpO2 levels may indicate the need for suctioning
   * Requires sterile technique

**Sleep chap 45=1 questions**

1. **Do people have one or more sleep cycles throughout the time that they sleep?**
   * Yes, people have multiple sleep cycles throughout a period of sleep……..

**Pain chap 46= 2 questions**

1. **What are the correct nursing actions when working with patients in pain?**
   * Assessing pain location, intensity, and quality
     + And selecting relief measures accordingly
   * **Being non-judgmental**
   * Take the patient’s pain seriously
   * Realize that each individual’s experience of pain is personal and unique
     + It may be affected by personality, cognitive abilities, perceived gender roles, culture, religion, developmental phase, personal pain history, etc. etc....
   * Use non-pharmacologic pain relief measures in addition to medications to maximize well-being
   * Relieve pain before it becomes severe
   * Provide for pain relief before planned activities
2. **What is the most important interaction for a nurse to take when working with patients in pain?**
   * **Treat the pain** according to its intensity**,** and then **evaluate the pain level after medicating** at the interval at which the medication should have taken effect to make sure the patient is experiencing relief. If they’re not experiencing relief – address it!

**Nutrition chap 47=2 questions**

1. **What item will you include in the diet of an elderly immobile patient?**
   * **High protein, high fiber foods**
   * Examples:
     + Animal proteins, including dairy, eggs, fish, and meat
     + Vegetables (fiber)
     + Legumes and Grains (protein and fiber)
     + The client’s favorite foods
     + Supplemental shakes such as Ensure
2. **Normal and abnormal albumin levels what they indicate.**
   * Albumin is a serum protein, whose level provides an estimate of the body’s protein stores
     + **Therefore, malnutrition is indicated by low albumin level**
   * Albumin concentrations change slowly, so if the level is low, it is indicative of prolonged protein depletion
     + It can also indicate altered liver function, hydration status (high albumin = dehydration), and losses from open wounds and burns
   * Normal albumin blood level = 3.4-5.0 g/dL

**Urinary Elimination Problems chap 48=2 questions**

1. **The procedure for collecting a “clean catch” urine specimen**
   * **Wash and dry the genital area**
     + Males: using a towelette, cleanse the urinary meatus by moving in a circular motion from the center of the urethral opening around the glans and down the distal portion of the shaft of the penis (retract foreskin if uncircumcised)
     + Females: spread the labia minora with one hand, and with the other cleanse the perineal area from front to back using a towelette
   * Begin voiding into the toilet/bedpan
   * Take the lid off the specimen container
   * Place the specimen container under the urethra (not touching the body), **and collect a midstream sample.**
   * Re-cap the container
   * Clean the outside of the container with disinfectant if necessary
   * Label the specimen and transport it to the lab immediately
     + Use a bag with a biohazard label on it
   * Document ☺
2. **Why is it important to check the BUN and creatinine prior to a patient receiving IV contrast for a CT scan?**
   * **Patients with impaired kidney function won’t be able to clear the dye**
   * There have been at least a few cases where patients have died due to receiving IV contrast during undiagnosed renal disease

**Bowel Elimination Problems chap 49= 1 question**

1. **Is it possible to lose the urge to defecate?**
   * **Yes**

**Perioperative Nursing chap 37=7 questions**

1. **What does a nurse need to assess on a post op abdominal surgery patient before you allow her/him to eat or drink something.**
   * **Bowel Sounds and ability to swallow**
   * Absent bowel sounds are expected for a short time after surgery (they can be caused by the anesthesia and handling of the bowel during abdominal surgery), but must return before oral intake can be resumed
   * Start slow with reintroduction of fluids and foods
     + Small amounts of clear liquids first, gradually progressing to a regular diet
2. **What is the most important nursing interaction to include in the care plan of a surgical patient who smokes?**
   * **Incentive spirometry**
   * **Deep breathing & coughing**
   * **Place nicotine patch**
3. **A patient is receiving heparin for a DVT, the doctor orders Coumadin, what is the most appropriate action for the nurse to take?**
   * **Before administering Coumadin, test PT/PTT/INR**
     + To determine the correct dose
   * **You can give both together, but heparin should be titrated down during the transition.**
4. **What information will you include in preoperative patient teaching?**
   * **Coughing, deep breathing, splinting, incentive spirometry, repositioning**
   * What will happen and what the client will experience
   * Psychosocial support to reduce anxiety
   * The role of the client and support people in preoperative preparation, the surgical procedure, and during the postoperative phase
   * Deep breathing & coughing, incentive spirometer, exercises (things patients have to do to reduce postop complications)
     + Deep-breathing and coughing
       - Frequency: q1-2h
       - Rationale: deep breathing exercises hyperinflate the alveoli (small parts of the lungs) and prevent them from collapsing). It improves lung expansion & volume, helps expel anesthetic gases and mucous from the airway, and improves oxygenation of body tissues. Coughing helps remove retained mucous from the respiratory tract
     + Splinting
       - Frequency: whenever performing DB&C, sitting up or changing positions in bed, getting in or OOB, and ambulating
       - Rationale: provides support to surgical incisions, thus reducing pain when performing the above actions. Reassure the client that this will not harm the incision.
   * Isometric, isotonic, gluteal-setting and quad-setting exercises as permitted
   * Teach about dietary restrictions/progression
   * Usually, tell them to drink plenty of fluids post-op to prevent dehydration/infection
5. **What are the signs and symptoms of deep vein thrombosis? This is taught in many different areas to help narrow it down, you can find this on page 875 in Smeltzer.**
   * **Redness, swelling, warmth**
     + You may also see a line of demarcation
   * **Positive Homan’s sign**
     + Pain going up the back of the calf
6. **What are signs and symptoms of pulmonary embolism? Page 978 has a brief description.**
   * Sudden chest pain, **SOB,** cyanosis, **diaphoresis,** shock (tachycardia, tachypnia, low BP - **the client looks like he/she is having a panic attack**)
7. **What is the proper technique for using incentive spirometry?**
   * Hold or place the spirometer in an upright position.
   * Exhale normally
   * Seal the lips tightly around the mouthpiece.
   * **Take in a slow, deep breath to elevate the balls or cylinder, and then hold the breath for 2 seconds initially, increasing to 6 seconds (optimum), to keep the balls or cylinder elevated if possible**
     + Sustained elevation of the balls or cylinder ensures adequate ventilation of the alveoli
   * If you have difficulty breathing only through the mouth, a nose clip can be used
   * Remove the mouthpiece and exhale normally
   * Cough after the incentive effort. Deep ventilation may loosen secretions, and coughing can facilitate their removal
   * Relax, and take several normal breaths before using the spirometer again
   * Repeat the procedure several times and then four or five times hourly. Practice increases inspiratory volume, maintains alveolar ventilation, and prevents Atelectasis
   * Clean the mouthpiece with water and shake it dry.
   * **Document level attained**

**Wound Care chap 36=2 questions**

1. **Know the stages of skin ulcers, signs and symptoms of each.**
   * Stage I – nonblanchable erythema
   * Stage II – partial-thickness skin loss (abrasion, blister, or shallow crater) involving the epidermis and possibly the dermis
   * Stage III – full-thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue
   * Stage IV – full-thickness skin loss with tissue necrosis or damage to muscle, bone, or supporting structures, such as a tendon or joint capsule. Undermining and sinus tracts may also be present
   * Eschar-covered? – unstageable!
2. **What is the definition of a shearing force?**
   * A combination of friction and pressure.
   * It occurs commonly when a client assumes a sitting position in bed
     + The body tends to slide downward toward the foot of the bed, transmitting downward force to the sacral bone and deep tissues. Meanwhile, the skin over the sacrum adheres to the bed linens and don’t move downward with the deeper tissues.
       - Therefore, the shearing force occurs at the junction between superficial and deep tissues – damaging blood vessels and tissues

**Management of Patients with Neurologic Autoimmune Disorders:**

*Multiple Sclerosis chap 60 Smeltzer= no questions*

*Myasthenia Gravis chap 64 Smeltzer= no questions*

**Guillain-Barre Syndrome chap 64 Smeltzer= 1 question**

1. **What is the most important assessment of a patient with Guillain-Barré Syndrome?**
   * Guillain-Barré Syndrome can cause respiratory depression due to demyelination of the peripheral nerves that innervate the diaphragm and intercostal muscles. It can also cause pulmonary emboli, and the inability to clear secretions
     + **Therefore, breathing is the most important assessment**
   * It can also cause
     + Ascending muscle weakness
     + Areflexia
     + Blindness
     + Inability to swallow
     + Instability of the CV system (tachycardia, bradycardia, hypertension, orthostatic hypotension)
     + …but none of these has as high a priority as breathing!

**Management of Patients with Neurodegenerative Disorders:**

**Parkinson’s chap 65 Smeltzer=2 questions**

1. **What are the signs and symptoms of Parkinson’s disease?**
   * A gradual onset of tremor, rigidity, bradykinesia, and postural instability
2. **What is a possible nursing diagnosis for a patient in the end stage of Parkinson’s disease?**
   * NDx
     + *Impaired physical mobility* r/t muscle rigidity and motor weakness
       - ***Impaired skin integrity* r/t impaired physical mobility**
     + *Self-care deficits* (feeding, dressing, hygiene, and toileting) r/t tremor and motor disturbance
     + *Imbalanced nutrition: less than body requirements* r/t tremor, slowness in eating, difficulty in chewing and swallowing
     + *Impaired verbal communication* r/t decreased speech volume, slowness of speech, inability to move facial muscles
     + *Ineffective coping* r/t depression and dysfunction due to disease progression

*Huntington’s disease chap 65 Smeltzer= no questions*

*Alzheimer’s chap 65 Smeltzer= no questions*

**Amyotrophic Lateral Sclerosis chap65 Smeltzer=1 question**

1. **Why would a nurse have to be supportive to a patient and the family with ALS?**
   * **The patient retains total mental capacity – the deterioration is usually only physical**
     + The patient is probably completely aware of his/her deterioration, as the disease only affects motor neurons, so the patient still needs a lot of direct interaction and attention
     + The patient will feel trapped inside his/her own body
   * Nursing management is focused on interventions to maintain or improve function, well-being, and quality of life
   * The death will likely occur within 3-5 years of diagnosis, so the patient and family need emotional and psychological support to deal with anticipatory grieving and unexpected loss. They will also need help in making end-of-life care decisions.
     + The patient should be encouraged to complete an advance directive or “living will” as soon as possible to preserve his/her autonomy in decision-making

**Musculoskeletal Function**

**Assessment of Musculoskeletal Function chap 66 Smeltzer= 1question**

1. **In a patient with musculoskeletal pain and is thereby immobile, what is an appropriate nursing interaction?**
   * **Assess and control the pain**
     + Non-pharmacologic and pharmacologic measures
   * **Maintain skin integrity**
     + Prevent pressure ulcers
     + Reposition frequently
   * Implement embolus precautions
   * Increase fluids and fiber
   * Prevent loss of joint function
     + Implement PT as ordered – most likely limited to isometric and very light ROM exercises
   * Assess neurovascular status

**Management of Patients with Musculoskeletal Disorders:**

**Metabolic Bone Disorders chap 68 Smeltzer= 3 questions**

1. **What would you include in a plan of care for a patient with osteomyelitis?**
   * **Obtain C&S**
   * Control pain
     + Immobilize affected part
     + Administer pain meds as ordered
     + Use non-pharmacological pain management techniques
     + Elevate the extremity
   * Improve physical mobility within therapeutic limitations
     + Move the joints above and below the affected part though ROM
     + Encourage full participation in ADLs
   * Control and eradicate infection
     + Observe IV site for infection
     + Monitor for s/s of superinfection (oral or vaginal candidiasis; loose or foul-smelling stools)
     + Ensure adequate circulation to the affected area
   * **Patient Teaching**
     + **Treatment regimen**
       - **long-term effects of abx and how to minimize side/adverse effects**
         * **Diarrhea** 🡪 take Imodium
         * **Vaginal** or oral **yeast infections**
         * **Eat** yogurt to maintain intestinal flora
       - IV antibiotic self-administration
         * IV site maintenance
     + **Wound care**
       - Aseptic technique
     + Infection control
       - Hand-washing
     + The importance of follow-up healthcare appointments
2. **Why would a patient with osteoporosis be given a prescription for calcium supplements?**
   * **Osteoporosis pulls calcium out of bones** (higher osteoclast activity than osteoblast activity)**, so it needs to be replenished**
   * Supplementation is normally prescribed to ensure adequate calcium intake (in case diet alone is insufficient)
3. **What instructions should be included in a teaching plan for a patient with osteoporosis who is taking Fosamax?** 
   * Aldendronate (Fosamax) is a bisphosphonate medication that is very effective in preventing fractures in postmenopausal women with osteoporosis (promotes bone regeneration)
   * Do not administer at the same time as calcium and D-vit supplements
   * Take on an empty stomach
   * Take on arising in the morning
   * Take with a full glass of water
   * **Sit upright for 30-60 minutes following administration**

**Management of Patients with Musculoskeletal trauma chap 69 Smeltzer=6 questions**

1. **What nursing intervention should be used for a patient who has received cold therapy for a sprained ankle and has negative results?**
   * **Stop the ice, reassess, re-warm back to normal**
2. **What nursing intervention should be used for a patient who is wearing an ace bandage and has negative results?**
   * Remove it
   * Assess CMS
   * **Re-apply the bandage, but make it less tight**
3. **What is one of the most important nursing interactions in the first 24 hours after cast placement?**
   * **Neurovascular status**
     + **Assess CMS**
   * None of the other interactions are as important as this…
4. **How do you determine if Bucks Traction is applied correctly?**
   * Before applying:
     + Inspect the skin for abrasions and circulatory disturbances – these must be healthy to tolerate traction
     + Clean and dry the extremity
   * During application:
     + One nurse elevates and supports the affected extremity under the heel and knee while another nurse applies a foam boot and secures the Velcro straps around the leg
     + Do not apply excessive pressure over the malleolus and proximal fibula, as this can cause pressure ulcers and nerve damage
     + Care must be taken to prevent pressure over the peroneal nerve at the point where it passes around the neck of the fibula just below the knee
       - Pressure here can cause foot drop!
   * Countertraction must be used to achieve effective traction
     + This is usually supplied by the patient’s body wt and bed position adjustments
     + Have the patient in good body alignment when the traction is applied
     + The client should not turn from side to side (to prevent bony fragments from moving against one another) but may shift position slightly with assistance
   * After application
     + **The leg must always be in proper alignment**
       - If you see the leg is rotated externally or internally, something isn’t right…
     + Traction must never be interrupted
       - Do not remove weights (unless intermittent traction was prescribed)
       - Ropes must be unobstructed
       - Weights must hang freely and not rest on the bed or floor
     + Skin must be assessed
       - Always check circulation, motion, & sensation, and make sure there’s not a pressure area
       - Remove foam boot to inspect the skin of the ankle and Achilles tendon 3x a day
       - Palpate the area of the traction tapes directly to detect underlying tenderness
       - Provide back care at least q2h to prevent pressure ulcers
     + Use special mattress overlays (air-filled, high-density foam) to prevent pressure ulcers
     + Question the client regularly about sensation and ask him/her to move the toes and foot
       - Dorsiflexion indicates functioning of the peroneal nerve
       - Weakness of dorsiflexion or inversion of the foot might indicate pressure on the common peroneal nerve
       - Plantar flexion demonstrates functioning of the tibial nerve
     + Immediately investigate any complaint of a burning sensation under the traction bandage or boot
   * Check circulation at first q15-30mins and then q1-2h:
     + - Peripheral pulses, color, capillary refill, and temperature of the fingers and toes
   * Indicators of DVT (unilateral calf tenderness, warmth, redness, and swelling)
5. **What are the nursing interactions that a nurse will perform on a patient with a newly applied cast and she/he suspects compartment syndrome?**
   * **Raise extremity to level of heart, notify the physician, and prepare to have the case bivalved**
6. **Post operative care interventions to teach a patient who is being discharged after having a knee arthroscopy.**
   * The joint will be wrapped with a compression dressing to control swelling
   * Ice may be applied to control edema and enhance comfort
   * The joint may be kept extended and elevated to reduce swelling
   * Analgesics will be used to control pain
   * Which exercises and activities may be performed
   * **Notify the physician if you experience:**
     + **Increased pain**
     + **Increased swelling**
     + **Increased temperature**
     + The 5 P’s (pain (increased), pallor, pulselessness, paresthesia, paralysis)
7. **What is one of the most important nursing assessments of orthopedic patients?**
   * **Monitor neurovascular status q2-4h**
     + Temperature of foot/arm/hand
     + Color
     + Pulse
     + CMS - circulation, motion, & sensation
     + Abnormal = the five P’s (pain, pallor, pulselessness, paresthesia, paralysis)
   * Assess pin site for infection
     + S/S = redness, drainage, tenderness, pain, loosening of pin, fever
     + Note: some serious drainage is expected
   * Assess for excessive swelling
     + This can apply pressure to vessels and nerves and cause compartment syndrome
   * Compare postoperative assessment data to preoperative assessment data
   * i.e. – an absent pulse postoperatively is of concern unless the pulse was also absent preoperatively

**Musculoskeletal Care Modalities chap 67 Smeltzer=2 questions**

1. **What are the post operative complications of a total hip replacement?**
   * **Dislocation of the hip**
     + S/S
       - **Increased pain at the site, swelling, and immobilization**
       - Acute groin pain in the affected hip or increased discomfort
       - **Shortening of the leg**
       - **Abnormal internal or external rotation of the leg**
       - Restricted ability or inability to move the leg
       - Reported “popping” sensation in the hip
     + Tx
       - notify the surgeon, because the hop must be reduced and stabilized promptly so that the leg does not sustain circulatory and nerve damage
       - the leg may then be stabilized with Buck’s traction or a brace
     + Prevention
       - Keep proper extremity/body alignment
       - Teach the client
         * the leg should NEVER cross over the body
         * about positioning the leg in abduction and to avoid internal/external rotation, hyperextension, and acute flexion

This includes keeping the head of the bed at 60° or less

* + - * + not to sleep on the affected side
        + not to bend forward
        + to perform isometric quadriceps and gluteal setting exercises q1h while awake
      * Use an abduction splint, wedge pillow, or 2-3 pillows between the legs
      * Keep the operative hip in abduction when turning the patient in bed
      * Never flex the hip more than 90°
        + When using the fracture bedpan, instruct the patient to flex only the unaffected hip, and use the trapeze to lift the pelvis onto the pan
      * Take care when moving OOB
        + Initially, keep abduction devices between the legs
        + Encourage the patient to keep the affected hip in extension, using the unaffected leg to pivot (with assistance)
        + Protect the affected leg from adduction, flexion, external/internal rotation, and excessive weight-bearing
      * Use orthopedic chairs, semireclining wheelchairs and raised toilet seats (to minimize hip joint flexion)
      * Use a cradle boot to prevent leg rotation and support heel off the bed
  + Excessive wound drainage
    - S/S
      * Drainage >200-500mL in first 24h post-op
      * Drainage >30mL/8h after 48h post-op
    - Tx
      * Notify physician
      * Autotransfusion drainage system (drainage is filtered and reinfused)
      * Homologous blood transfusion may be needed if excessive blood loss was not anticipated
    - Prevention
      * Drainage with a portable suction device during first 48 hours post-op (until drainage <30mL/8h)
      * Monitor VS (observing for evidence of shock [hypotension, tachypnea, tachycardia])
      * Monitor volume and character of drainage
      * Monitor Hb and HCT
  + Thromboembolism
    - S/S
      * calf pain
      * swelling
      * tenderness
      * PE S/S = sudden dyspnea, tachypnea, pleuritic chest pain
    - Tx
      * Notify physician
      * Tx will depend on which measures have already been implemented, and whether or not patient has experienced PE
    - Prevention
      * Note: the incidence is 48% with patients who do not receive prophylaxis
      * Use anti-embolism stockings or SCD (request if not ordered)
        + Remove stockings for 20 minutes 2x a day
      * Administer antithrombotics as ordered
        + Fondaparinux (Arista)
        + Low-molecular-weight heparin (enozaparin [Lovenox], dalteparin [Fragmin])
      * Instruct the patient to change positions frequently (and how to do so safely)
      * Instruct the patient to perform isometric exercises every hour while awake
      * Assess for unilateral calf pain or tenderness q8h
      * Assess popliteal, dorsalis pedis, and posterior tibial pulses and avoid compression over these areas to maximize perfusion
      * Assess skin temperature of legs (areas of warmth may indicate underlying thrombus)
      * Monitor temp (fever may indicate inflammation)
      * Encourage fluids (dehydration increases blood viscosity, contributing to risk)
  + Infection
    - S/S
      * painful redness and swelling at site with increased/purulent drainage and fever
      * Delayed surgical infections (4-24m post-op) may cause return of discomfort to the hip
      * Loosening of the prosthesis may occur
    - Tx
      * Antibiotics
      * Surgical debridement may be necessary
      * Removal of the prosthesis may be necessary
    - Prevention
      * Begin preoperative skin preparation 1-2 days before the surgery to reduce microbes
      * Keep incision clean and dry
      * Change dressings frequently and use aseptic technique
        + Assess wound appearance and character of drainage during changes
      * Monitor VS (increased pulse, BP, or resp may indicate infection)
      * Remove indwelling urinary catheters or portable wound suction devices ASAP to avoid infection
      * Prophylactic abx are prescribed if the patient will be receiving future Sx or invasive procedures (i.e. tooth extraction, cytoscopic examination)
  + Heel Pressure Ulcer
    - S/S = nonblanchable redness or skin breakdown
    - Tx = eliminate pressure to affected area and treat wound as necessary
    - Prevention
      * Use a cradle boot to prevent leg rotation and support heel off the bed
  + Immobility-related complications
    - Pneumonia/Atelectasis
      * Prevention
        + Teach deep breathing, coughing,
        + Get the client ambulating within days of the Sx, adhering to the client’s specific weight-bearing limits and progressing as tolerated/prescribed
    - Neurovascular Dysfunction
      * S/S = pain, pallor, pulselessness, paresthesia, paralysis
      * Tx = notify the surgeon
      * Prevention
        + Teach ROM activities
        + teach isometric exercises
        + Elevate extremity
        + Assess for deep, throbbing, unrelenting pain; for dorsiflexion and plantar flexion abilities; capillary refill; for edema and leg tightness; color and temperature of extremity; peripheral pulses; ability to move foot and toes
  + Long-Term complications
    - Heterotopic ossification (formation of bone in the periprosthetic space)
    - Avascular necrosis (bone death caused by loss of blood supply)
  + Loosening of the prosthesis

1. **What is important to teach a patient who is prescribed Coumadin after a total knee replacement**
   * **Go for PT/INR levels – and how important it is to do so**
   * Many medications interact with Coumadin, so don’t start taking any new medications including herbs and OTC meds without first consulting your doctor
   * **Many foods affect Coumadin**, so you may benefit from a consultation with a dietician
     + Foods with high vitamin K levels, such as spinach, broccoli, and lettuce interact
     + Garlic also interacts
   * **Take measures to prevent bleeding**
     + Use an electric razor

**Nursing of Adults with Altered Safety and Protection:**

**HIV/AIDS chap 52 Smeltzer=2 question**

1. **What are the initial symptoms of active HIV/AIDS?**
   * **Cold/flu s/s –** nothing major
2. **What are the proper precautions to take when caring for a patient with HIV?**
   * **Standard Precautions**
     + Hand hygiene
       - after touching blood, body fluids, secretions, excretions, or contaminated items
       - immediately after removing gloves
       - between patient contacts
     + PPE
       - Gloves – use for touching anything on the patient or of the patient’s except dry, intact skin
       - Gown – use whenever contact of your clothing/exposed skin with blood or body fluids, secretions, and excretions is anticipated
       - Mask, eye protection, face shield – use whenever any splashes of blood or body fluids are expected (especially suctioning or endotracheal intubation)
     + Soiled patient care equipment
       - Handle in a manner that prevents transfer of microorganisms to others and the environment
       - Wear gloves if visibly contaminated
       - Perform hand hygiene
     + Environmental control
       - Develop procedures for routine care, cleaning, and disinfection of environmental surfaces, especially frequently touched surfaces in patient care areas
     + Textiles & laundry
       - Handle in a manner that prevents transfer of microorganisms to others and the environment
     + Needles & other sharps
       - Do not recap, bend, break, or hand-manipulate used needles
       - If recapping is required, use a one-handed scoop technique only
       - Use safety features when available
       - Place used sharps in a puncture-resistant container
     + Patient resuscitation
       - Use mouthpiece, resuscitation bag, and other ventilation devices to prevent contact with mouth and oral secretions
     + Patient placement
       - Prioritize single-patient room if patient is at increased risk of transmission, is likely to contaminate the environment, does not maintain appropriate hygiene, or is at increased risk of acquiring infection or developing adverse outcome following infection
     + Respiratory hygiene/cough etiquette
       - Instruct symptomatic people to:
         * cover mouth and nose when sneezing or coughing
         * Use tissues and dispose in no-touch receptacle
         * Observe hand hygiene after soiling of hands with respiratory secretions
         * Wear surgical mask if tolerated
   * Postexposure prophylaxis for healthcare providers
     + In response to exposure to blood or other body fluids
     + Procedure
       - Start them within 2 hours after exposure
       - Make sure you are being monitored for signs of toxicity
       - Practice safer sex until follow-up testing is complete
       - Continue HIV medications for full 4 weeks after exposure
       - The majority of exposures will warrant a combination of antiretroviral agents
     + Follow up with postexposure testing 1, 3, and 6 months and perhaps 1 year afterward

**Management of adults with Immunodeficiency chap 50 Smeltzer=5 questions**

1. **Types of immunity**
   * Natural (innate) Immunity
     + First line of defense
     + Respond to any injury
     + Always respond
     + Immediate response
     + Local response
     + Cells involved:
       - Monocytes & macrophages (phagocytic cells)
       - Dendritic cells
       - NK cells
       - Granulocytes (release cell mediators, such as histamine, Bradykinin, and prostaglandins; engulf foreign bodies)
         * Basophils
         * Eosinophils
         * Neutrophils (Inflammation first responders)
     + Early events in this kind of immunity are critical in determining the nature of the adaptive immune response
   * Acquired Immunity
     + Respond to specific substance
     + Need to be activated
     + Latent period
     + Systemic response
     + Types:
       - Active Immunity
         * i.e. - the immunity that results from contracting a disease
         * Lasts many years or even for the rest of a person’s life
       - Passive Immunity
         * i.e. - receiving vaccinations against a disease; colostrum; receiving immunoglobulin
         * More temporary than active immunity
     + Mechanisms:
       - Cell-mediated response
         * T-cell differentiation into cytotoxic or Killer T-cells which stab and kill foreign cells
       - Humoral response
   * Production of Ab’s by B-cells that differentiate into plasma cells
2. **What patients are at a higher risk for an infection?**
   * Diabetics
     + Increased risk of infection associated with vascular insufficiency, neuropathy, and poor control of serum glucose levels (bacteria love glucose)
   * HIV/AIDS Patients
     + Interferes with the activity of Helper T cells
   * COPD Patients
     + Causes altered breathing function and ineffective airway clearance, which can lead to infection
   * Patients with renal impairment
     + Causes a deficiency in circulating lymphocytes
     + Causes acidosis and accumulation of uremic toxins, which alter immune defenses
   * Patient’s whose immune organ(s) have been removed
     + LN’s, spleen, thymus
   * SCID (Severe Combined Immunodeficiency) Sufferers
     + Marked deficit of T and B cells
   * Patients with poor nutrition – if chronic, increases a person’s risk for infection
   * Stressed Patients – the immune system is integrated with psychophysiologic processes, and can therefore be impaired by acute or prolonged stress levels – mindset is integral to overall health – optimism can actually improve disease outcomes
3. **Physiologic findings in patients with a systemic infection.**
   * **WBC elevation**
   * **Lymphadenopathy**
   * Fever
   * LOCAL Infection: redness and swelling at a particular site
4. **What is it imperative for a patient to do when taking an antibiotic for infection at home?**
   * **Finish the entire course of treatment even if you feel better**
5. **What is the most effective way to prevent infection in a patient who is neutropenic?**
   * **Hand-washing**
   * **Reverse contact isolation if the neutrophil count is really low**

**Management of Patient’s with Autoimmune Disorders chap54 Smeltzer=5 questions**

1. **What precautions do people with SLE need to take to avoid exacerbation of the disease?**
   * **Decrease stress**
     + Stress can increase disease activity
   * **Avoid sunlight** (and obviously also don’t use tanning beds!!)
     + UV radiation can increase disease activity or cause an exacerbation
     + Wear protective clothing and sunscreen
   * Keep going for regular checkups and screenings
     + Many organ systems can become involved, and the sooner these symptoms are discovered the better
   * Eat a healthy diet
     + SLE increases the risk of CV disease (including HT and atherosclerosis)
2. **What are symptoms of a problem for a patient with SLE taking aspirin?**
   * Bleeding gums when brushing teeth, purpura, ecchymoses
     + **S/S of** **Bleeding**
   * Jaundice, elevated LFTs
     + Aspirin’s adverse effect of hepatotoxicity is more common in patients with SLE!
3. **What things would you include in a teaching plan for a young woman with RA?**
   * **Inform HCP of intended pregnancy**
     + **Medications used to treat RA may be contraindicated during pregnancy**
       - Methotrexate is Category X – it is teratogenic
       - Celecoxib is Category C – and can cause birth defect in late pregnancy
       - Ibuprofen is Category C for the first 30 weeks and Category D thereafter
       - Naproxen is Category B in the first trimester but can cause birth defects in late pregnancy
       - Aspirin is Category D
       - Biologics are generally only to be used if clearly necessary
       - Almost all of these meds should not be taken while breastfeeding
   * Techniques to control pain
     + Medications and non-pharm techniques
   * **Use of assistive devices**
   * The importance of returning for regular check-ups and blood work
     + If the patient is on DMARDs, blood testing will be required q2-4 weeks
   * Referral to support groups, such as the Arthritis Foundation chapter in the patient’s area
   * Balancing activity and rest
     + Certain exercises to promote mobility
     + Swimming in a heated pool
     + Getting plenty of sleep
     + Principles of joint protection and work simplification
   * Eating a balanced diet
     + High in omega-3’s, which are anti-inflammatory
     + High in selenium (which is good for joints)
     + Low in saturated fat (because RA can lead to CV disease including Pericarditis and atherosclerosis)
4. **Intervention for the relief of joint stiffness in patients with RA.**
   * **Heat and NSAIDs**
   * Keep the joints moving within therapeutic limitations – immobility will only make them more stiff, and can cause other complications such as contractures
5. **What information will a nurse give to a patient to help them avoid the side effects of prednisone**
   * Don’t stop taking it suddenly
     + This may cause adrenal insufficiency
   * **Take with food**
     + It can be rough on the GI tract
     + But don’t drink grapefruit juice during therapy
   * **Watch BG**
     + Prednisone can cause hyperglycemia
   * **Stay away from crowds, ill people**
     + Prednisone suppresses the immune system
   * Eat a healthy diet and remain as active as possible
     + Prednisone stimulates the appetite, which when combined with inactivity can lead to weight gain
   * Discuss possible effects on body image (r/t weight gain and cushingoid appearance)
     + Prepare the patient, and explore coping mechanisms
   * Return for regular lab testing as ordered

**Nursing Management in Cancer Care chap 16 Smeltzer=9 questions**

1. **When does the American Cancer Society recommend a woman to start having mammograms and how often?**
   * **40 years old, annually**
2. **Common side effects of long term opioid use and interventions to manage them.**
   * Tolerance
     + Increase the dose as ordered to maintain effective pain relief
     + Note: this does not indicate addiction – physical tolerance usually occurs in the absence of addiction
   * **Constipation**
     + **High fiber diet**
     + Increased fluid intake
     + **Stool softeners**
     + **Ambulation**
   * Risk for impaired skin integrity secondary to morphine-induced pruritus
     + Administer antihistamines for itchiness
     + Keep fingernails short, and instruct patient to try not to scratch him/herself
   * Addiction (This is actually an uncommon problem)
     + Taper dose slowly to avoid withdrawal symptoms
3. **Interventions for cancer patients with a nursing diagnosis of altered nutrition.**
   * Determine the etiology of the altered nutrition
   * Teach patient to avoid unpleasant sights, odors, sounds in the environment during mealtime
   * Suggest foods that are preferred and well tolerated by the patient, preferably high-calorie and high-protein foods. Respect ethnic and cultural food preferences
     + **Avoid spicy or acidic foods**
   * Encourage adequate fluid intake, but limit fluids at mealtime
   * Suggest smaller, more frequent meals
   * Promote relaxed, quiet environment during mealtime with increased social interaction as desired
   * If patient desires, serve wine at mealtime with foods
     + …really???
   * Consider cold foods, if desired
     + **But no extremes of hot or cold**
   * **Encourage nutritional supplements** and high-protein foods between mealtimes
   * **Encourage frequent oral hygiene**
     + **Treat any oral mucosa issues**
   * Provide pain relief measures
   * Provide control of nausea and vomiting
   * Increase activity level as tolerated
   * Decrease anxiety by encouraging verbalization of fears, concerns; use of relaxation techniques; imagery at mealtime
   * Position patient properly at mealtimes
   * For collaborative management, provide enteral tube feedings of commercial liquid diets, elemental diets, or blenderized foods as prescribed
   * Provide parenteral nutrition with lipid supplements as prescribed
   * Administer appetite stimulants as prescribed
   * Encourage family and friends not to nag or cajole patient about eating
4. **Techniques a nurse will teach a patient who is receiving radiation therapy who has mouth lesions or fatigue.**
   * **Mouth lesions**
     + Perform oral hygiene frequently
       - But don’t use alcohol-based mouthwash
       - Use saline mouth rinse q2h
     + Avoid irritants such as alcohol, tobacco and spicy foods
     + Avoid foods that are extremely hot or cold
     + Brush with a soft toothbrush or toothette, use a nonabrasive toothpaste, and floss q24h unless painful or platelets fall below 40,000 cu/mm
     + Apply water-soluble lip lubricant
     + Eat soft foods
     + **Lidocaine can help, but you need to be careful as it can cause aspiration**
   * **Fatigue**
     + **Take frequent rest periods**
     + Get plenty of sleep
     + Ask for help
     + Reduce job workload by reducing hours worked per week
     + Get adequate protein/calorie intake
     + Drink plenty of fluids
     + Exercise
5. **Ways in which a nurse can help a person with alopecia to improve her self esteem.**
   * **Encourage her to buy a wig before she loses her hair**
   * Take a photograph of yourself to the wig shop to assist in selection
   * Contact the ACS for donated wigs, or a store that specializes in this product
   * Wear a hat, scarf, or turban
   * Encourage the client to wear own clothes and retain social contacts to maintain personal identity
   * Explain that hair growth usually begins once therapy is completed
6. **Things to include in patient education for patients receiving chemotherapy.**
   * **Prepare the patient for side effects**
     + **Nausea/vomiting**
       - **Take antiemetics**
       - Employ nonpharm therapy such as relaxation, imagery and acupressure
       - Dietary precautions such as small, frequent, bland, comforting meals
     + Stomatitis
       - See recommendations in #82 and 83
     + **Alopecia**
     + **Diarrhea**
       - **Take immodium**
     + Myelosuppression
       - Keep all appointments to assess hematologic, hepatic, renal, cardiovascular, and pulmonary systems
       - Be careful to prevent injury or bleeding
       - Monitor for infection
         * Redness, swelling, lymphadenopathy, fever
       - Anticipate febrile neutropenia at time of nadir counts
     + Hemorrhagic cystitis
       - Watch out for blood in the urine and report this to the HCP
       - Pulmonary edema
       - Notify HCP if onset of dyspnea and cough, which may rapidly progress to acute respiratory distress and subsequent respiratory failure
     + Sterility
       - Don’t assume sterility has resulted, so use reliable birth control
       - For male patients, consider banking sperm if you still want to have children
     + Neurotoxicity
       - Report NS effects ASAP so that more damage can be prevented
     + Hypersensitivity Reactions
       - Recognize the S/S of hypersensitivity and report to HCP or ER to avoid anaphylaxis
7. **What is the most important nursing interaction when caring for a chemotherapy patient in the nadir of treatment?**
   * Nadir = the point at which the WBC count is the lowest after a therapy (i.e. chemo) that has a toxic effect on the bone marrow
   * **Higher risk of infection**
   * **Higher incidence of bleeding**
8. **What is the purpose of hormonal therapy in cancer treatment?**
   * **It will slow the cancer process, depending on the type of cancer**
   * It is used as an adjuvant therapy after primary treatment
   * Susceptible cancers include breast cancer and prostate cancer
9. **Signs and symptoms of Superior Vena Cava Syndrome.**
   * S/S
     + Gradually or suddenly impaired venous drainage giving rise to:
       - Progressive dyspnea, cough, hoarseness, chest pain, and **facial swelling**
       - **Edema of the neck, arms, hands, and thorax** and reported sensation of skin tightness and difficulty swallowing
       - Possibly engorged and distended jugular, temporal, and arm veins
       - Dilated thoracic vessels, causing prominent venous patterns on the chest wall
       - Increased ICP, associated visual disturbances, headache, and altered mental status

**Management of Patients with Hematologic Disorders chap 33 Smeltzer= 8 questions**

1. **What are the symptoms of anemia?**
   * **Pallor**
   * **Fatigue**
   * Slight tachycardia on exertion
   * Vascular collapse (if severe)
2. **What is the most important nursing intervention when administering a blood transfusion?**
   * **Assessing for adverse reactions!!**
   * S/S include , hives, nausea, vomiting, torso or back pain, shortness of breath, flushing, hematuria, fever, or chills
3. **Know at what hemoglobin level a patient will require blood transfusions.**
   * **Usually <8g/dL**
4. **Nursing interventions for patients in sickle cell crisis.**
   * Sickle cell disease is a genetic hemolytic anemia that causes deformity of the RBCs under low oxygen conditions
   * The 3 types of sickle cell crisis
     + Sickle Crisis
       - Very painful; results from tissue hypoxia and necrosis due to impaired blood flow to a specific region, tissue or organ
     + Aplastic Crisis
       - Results from parvovirus infection; the hemoglobin levels fall rapidly and the bone marrow can’t compensate, AEB an absence of reticulocytes
     + Sequestration Crisis
       - Results when organs pool the sickled cells.
       - In children, the organ most commonly involved is the spleen
       - In adults, the organ most commonly involved is the liver; or more dangerously the lungs
   * Interventions
     + Assess and manage pain
       - Assess factors that may precipitate or alleviate pain
       - Administer aspirin, NSAIDs, or opioid analgesics as indicated
       - Implement PT
       - Implement physiotherapy (heat applications, massage, exercise)
       - Implement cognitive and behavioral interventions (meditation, imagery, distraction, relaxation, motivational therapy)
     + Maintain adequate hydration
       - Assess for dehydration
       - Encourage oral intake
       - Administer IV fluids (i.e. – D5W) as ordered
     + Promote coping skills
       - Managing the patient’s pain well helps establish trust
       - Focus on the patient’s strengths rather than deficits
       - Provide the patient with opportunities to make decisions to promote sense of control
     + Minimize deficient knowledge
       - Help the patient understand what can precipitate crises to avoid them in the future
       - Instruct the patient to keep warm and maintain adequate hydration
       - Inform women of childbearing age that hydroxyurea can harm unborn children
     + Administer O2 therapy as needed
     + Administer hydroxyurea (Hydrea) as ordered
     + Implement blood transfusions as ordered (esp. for aplastic crisis)
     + Administer folic acid supplementation as ordered
     + Other assessments
       - Assess for cardiac involvement
       - Assess for pulmonary involvement
       - Assess for infections (esp of the chest, long bones, and femoral head)
5. **How do you assess a patient with leukemia for platelet dysfunction?**
   * ….Take a blood test
   * **Ask if their gums bleed when they brush their teeth**
   * Assess for presence of purpura
   * Assess for presence of ecchymoses
6. **Which electrolyte imbalance would you expect for a patient with multiple myeloma?**
   * **Hypercalcemia**
7. **What surgical procedure is used in patients with immune thrombocytopenic purpura (ITP)?**
   * **Splenectomy**
8. **What medication order would you question when caring for a patient with thrombocytopenia?**
   * **Aspirin**
   * Other meds that may cause bleeding